

AMENDED IN ASSEMBLY MAY 8, 2014

AMENDED IN ASSEMBLY MAY 1, 2014

AMENDED IN ASSEMBLY APRIL 9, 2014

AMENDED IN SENATE FEBRUARY 14, 2013

**SENATE BILL**

**No. 20**

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**Introduced by Senator Hernandez**

December 3, 2012

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An act to amend Section 1399.849 of the Health and Safety Code, and to amend Section 10965.3 of the Insurance Code, relating to health care coverage, *and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 20, as amended, Hernandez. Individual health care coverage: enrollment periods.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer, on and after October 1,

2013, to offer, market, and sell all of the plan's insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, as specified, but requires plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. Existing law requires a plan or insurer to provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

This bill would require a plan or insurer to provide an annual enrollment period for the policy year beginning on January 1, 2015, from November 15, 2014, to February 15, 2015, inclusive.

Because a willful violation of that requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

*This bill would declare that it is to take effect immediately as an urgency statute.*

Vote: ~~majority~~<sup>2/3</sup>. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1     SECTION 1. Section 1399.849 of the Health and Safety Code  
2     is amended to read:  
3     1399.849. (a) (1) On and after October 1, 2013, a plan shall  
4     fairly and affirmatively offer, market, and sell all of the plan's  
5     health benefit plans that are sold in the individual market for policy  
6     years on or after January 1, 2014, to all individuals and dependents  
7     in each service area in which the plan provides or arranges for the  
8     provision of health care services. A plan shall limit enrollment in  
9     individual health benefit plans to open enrollment periods, annual  
10    enrollment periods, and special enrollment periods as provided in  
11    subdivisions (c) and (d).

1 (2) A plan shall allow the subscriber of an individual health  
2 benefit plan to add a dependent to the subscriber's plan at the  
3 option of the subscriber, consistent with the open enrollment,  
4 annual enrollment, and special enrollment period requirements in  
5 this section.

6 (b) An individual health benefit plan issued, amended, or  
7 renewed on or after January 1, 2014, shall not impose any  
8 preexisting condition provision upon any individual.

9 (c) (1) A plan shall provide an initial open enrollment period  
10 from October 1, 2013, to March 31, 2014, inclusive, an annual  
11 enrollment period for the policy year beginning on January 1, 2015,  
12 from November 15, 2014, to February 15, 2015, inclusive, and  
13 annual enrollment periods for policy years beginning on or after  
14 January 1, 2016, from October 15 to December 7, inclusive, of the  
15 preceding calendar year.

16 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
17 of Federal Regulations, for individuals enrolled in noncalendar  
18 year individual health plan contracts, a plan shall also provide a  
19 limited open enrollment period beginning on the date that is 30  
20 calendar days prior to the date the policy year ends in 2014.

21 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
22 a plan shall allow an individual to enroll in or change individual  
23 health benefit plans as a result of the following triggering events:

24 (A) He or she or his or her dependent loses minimum essential  
25 coverage. For purposes of this paragraph, the following definitions  
26 shall apply:

27 (i) "Minimum essential coverage" has the same meaning as that  
28 term is defined in subsection (f) of Section 5000A of the Internal  
29 Revenue Code (26 U.S.C. Sec. 5000A).

30 (ii) "Loss of minimum essential coverage" includes, but is not  
31 limited to, loss of that coverage due to the circumstances described  
32 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
33 Code of Federal Regulations and the circumstances described in  
34 Section 1163 of Title 29 of the United States Code. "Loss of  
35 minimum essential coverage" also includes loss of that coverage  
36 for a reason that is not due to the fault of the individual.

37 (iii) "Loss of minimum essential coverage" does not include  
38 loss of that coverage due to the individual's failure to pay  
39 premiums on a timely basis or situations allowing for a rescission,  
40 subject to clause (ii) and Sections 1389.7 and 1389.21.

1 (B) He or she gains a dependent or becomes a dependent.

2 (C) He or she is mandated to be covered as a dependent pursuant  
3 to a valid state or federal court order.

4 (D) He or she has been released from incarceration.

5 (E) His or her health coverage issuer substantially violated a  
6 material provision of the health coverage contract.

7 (F) He or she gains access to new health benefit plans as a result  
8 of a permanent move.

9 (G) He or she was receiving services from a contracting provider  
10 under another health benefit plan, as defined in Section 1399.845  
11 or Section 10965 of the Insurance Code, for one of the conditions  
12 described in subdivision (c) of Section 1373.96 and that provider  
13 is no longer participating in the health benefit plan.

14 (H) He or she demonstrates to the Exchange, with respect to  
15 health benefit plans offered through the Exchange, or to the  
16 department, with respect to health benefit plans offered outside  
17 the Exchange, that he or she did not enroll in a health benefit plan  
18 during the immediately preceding enrollment period available to  
19 the individual because he or she was misinformed that he or she  
20 was covered under minimum essential coverage.

21 (I) He or she is a member of the reserve forces of the United  
22 States military returning from active duty or a member of the  
23 California National Guard returning from active duty service under  
24 Title 32 of the United States Code.

25 (J) With respect to individual health benefit plans offered  
26 through the Exchange, in addition to the triggering events listed  
27 in this paragraph, any other events listed in Section 155.420(d) of  
28 Title 45 of the Code of Federal Regulations.

29 (2) With respect to individual health benefit plans offered  
30 outside the Exchange, an individual shall have 60 days from the  
31 date of a triggering event identified in paragraph (1) to apply for  
32 coverage from a health care service plan subject to this section.  
33 With respect to individual health benefit plans offered through the  
34 Exchange, an individual shall have 60 days from the date of a  
35 triggering event identified in paragraph (1) to select a plan offered  
36 through the Exchange, unless a longer period is provided in Part  
37 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
38 A of Title 45 of the Code of Federal Regulations.

39 (e) With respect to individual health benefit plans offered  
40 through the Exchange, the effective date of coverage required

pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to individual health benefit plans offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 1399.855. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day

1 of the second month following delivery or postmark of the  
2 payment.

3 (4) With respect to an individual health benefit plan for which  
4 an individual applies during a special enrollment period described  
5 in subdivision (d), the following provisions shall apply:

6 (A) When the individual submits a premium payment, based  
7 on the quoted premium charges, and that payment is delivered or  
8 postmarked, whichever occurs earlier, within the first 15 days of  
9 the month, coverage under the plan shall become effective no later  
10 than the first day of the following month. When the premium  
11 payment is neither delivered nor postmarked until after the 15th  
12 day of the month, coverage shall become effective no later than  
13 the first day of the second month following delivery or postmark  
14 of the payment.

15 (B) Notwithstanding subparagraph (A), in the case of a birth,  
16 adoption, or placement for adoption, the coverage shall be effective  
17 on the date of birth, adoption, or placement for adoption.

18 (C) Notwithstanding subparagraph (A), in the case of marriage  
19 or becoming a registered domestic partner or in the case where a  
20 qualified individual loses minimum essential coverage, the  
21 coverage effective date shall be the first day of the month following  
22 the date the plan receives the request for special enrollment.

23 (g) (1) A health care service plan shall not establish rules for  
24 eligibility, including continued eligibility, of any individual to  
25 enroll under the terms of an individual health benefit plan based  
26 on any of the following factors:

27 (A) Health status.

28 (B) Medical condition, including physical and mental illnesses.

29 (C) Claims experience.

30 (D) Receipt of health care.

31 (E) Medical history.

32 (F) Genetic information.

33 (G) Evidence of insurability, including conditions arising out  
34 of acts of domestic violence.

35 (H) Disability.

36 (I) Any other health status-related factor as determined by any  
37 federal regulations, rules, or guidance issued pursuant to Section  
38 2705 of the federal Public Health Service Act.

39 (2) Notwithstanding Section 1389.1, a health care service plan  
40 shall not require an individual applicant or his or her dependent

1 to fill out a health assessment or medical questionnaire prior to  
2 enrollment under an individual health benefit plan. A health care  
3 service plan shall not acquire or request information that relates  
4 to a health status-related factor from the applicant or his or her  
5 dependent or any other source prior to enrollment of the individual.

6 (h) (1) A health care service plan shall consider as a single risk  
7 pool for rating purposes in the individual market the claims  
8 experience of all insureds and enrollees in all nongrandfathered  
9 individual health benefit plans offered by that health care service  
10 plan in this state, whether offered as health care service plan  
11 contracts or individual health insurance policies, including those  
12 insureds and enrollees who enroll in individual coverage through  
13 the Exchange and insureds and enrollees who enroll in individual  
14 coverage outside of the Exchange. Student health insurance  
15 coverage, as that coverage is defined in Section 147.145(a) of Title  
16 45 of the Code of Federal Regulations, shall not be included in a  
17 health care service plan's single risk pool for individual coverage.

18 (2) Each calendar year, a health care service plan shall establish  
19 an index rate for the individual market in the state based on the  
20 total combined claims costs for providing essential health benefits,  
21 as defined pursuant to Section 1302 of PPACA, within the single  
22 risk pool required under paragraph (1). The index rate shall be  
23 adjusted on a marketwide basis based on the total expected  
24 marketwide payments and charges under the risk adjustment and  
25 reinsurance programs established for the state pursuant to Sections  
26 1343 and 1341 of PPACA. The premium rate for all of the health  
27 care service plan's health benefit plans in the individual market  
28 shall use the applicable index rate, as adjusted for total expected  
29 marketwide payments and charges under the risk adjustment and  
30 reinsurance programs established for the state pursuant to Sections  
31 1343 and 1341 of PPACA, subject only to the adjustments  
32 permitted under paragraph (3).

33 (3) A health care service plan may vary premium rates for a  
34 particular health benefit plan from its index rate based only on the  
35 following actuarially justified plan-specific factors:

36 (A) The actuarial value and cost-sharing design of the health  
37 benefit plan.

38 (B) The health benefit plan's provider network, delivery system  
39 characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding user fees required by the Exchange.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

(j) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), subdivisions (a), (b), and (g) shall become inoperative 12 months after that repeal or amendment.

SEC. 2. Section 10965.3 of the Insurance Code is amended to read:

10965.3. (a) (1) On and after October 1, 2013, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services. A health insurer shall limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer shall allow the policyholder of an individual health benefit plan to add a dependent to the policyholder's health benefit plan at the option of the policyholder, consistent with the open enrollment, annual enrollment, and special enrollment period requirements in this section.



1 (b) An individual health benefit plan issued, amended, or  
2 renewed on or after January 1, 2014, shall not impose any  
3 preexisting condition provision upon any individual.

4 (c) (1) A health insurer shall provide an initial open enrollment  
5 period from October 1, 2013, to March 31, 2014, inclusive, an  
6 annual enrollment period for the policy year beginning on January  
7 1, 2015, from November 15, 2014, to February 15, 2015, inclusive,  
8 and annual enrollment periods for policy years beginning on or  
9 after January 1, 2016, from October 15 to December 7, inclusive,  
10 of the preceding calendar year.

11 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
12 of Federal Regulations, for individuals enrolled in noncalendar-year  
13 individual health plan contracts, a health insurer shall also provide  
14 a limited open enrollment period beginning on the date that is 30  
15 calendar days prior to the date the policy year ends in 2014.

16 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
17 a health insurer shall allow an individual to enroll in or change  
18 individual health benefit plans as a result of the following triggering  
19 events:

20 (A) He or she or his or her dependent loses minimum essential  
21 coverage. For purposes of this paragraph, both of the following  
22 definitions shall apply:

23 (i) “Minimum essential coverage” has the same meaning as that  
24 term is defined in subsection (f) of Section 5000A of the Internal  
25 Revenue Code (26 U.S.C. Sec. 5000A).

26 (ii) “Loss of minimum essential coverage” includes, but is not  
27 limited to, loss of that coverage due to the circumstances described  
28 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
29 Code of Federal Regulations and the circumstances described in  
30 Section 1163 of Title 29 of the United States Code. “Loss of  
31 minimum essential coverage” also includes loss of that coverage  
32 for a reason that is not due to the fault of the individual.

33 (iii) “Loss of minimum essential coverage” does not include  
34 loss of that coverage due to the individual’s failure to pay  
35 premiums on a timely basis or situations allowing for a rescission,  
36 subject to clause (ii) and Sections 10119.2 and 10384.17.

37 (B) He or she gains a dependent or becomes a dependent.

38 (C) He or she is mandated to be covered as a dependent pursuant  
39 to a valid state or federal court order.

40 (D) He or she has been released from incarceration.

1 (E) His or her health coverage issuer substantially violated a  
2 material provision of the health coverage contract.

3 (F) He or she gains access to new health benefit plans as a result  
4 of a permanent move.

5 (G) He or she was receiving services from a contracting provider  
6 under another health benefit plan, as defined in Section 10965 or  
7 Section 1399.845 of the Health and Safety Code, for one of the  
8 conditions described in subdivision (a) of Section 10133.56 and  
9 that provider is no longer participating in the health benefit plan.

10 (H) He or she demonstrates to the Exchange, with respect to  
11 health benefit plans offered through the Exchange, or to the  
12 department, with respect to health benefit plans offered outside  
13 the Exchange, that he or she did not enroll in a health benefit plan  
14 during the immediately preceding enrollment period available to  
15 the individual because he or she was misinformed that he or she  
16 was covered under minimum essential coverage.

17 (I) He or she is a member of the reserve forces of the United  
18 States military returning from active duty or a member of the  
19 California National Guard returning from active duty service under  
20 Title 32 of the United States Code.

21 (J) With respect to individual health benefit plans offered  
22 through the Exchange, in addition to the triggering events listed  
23 in this paragraph, any other events listed in Section 155.420(d) of  
24 Title 45 of the Code of Federal Regulations.

25 (2) With respect to individual health benefit plans offered  
26 outside the Exchange, an individual shall have 60 days from the  
27 date of a triggering event identified in paragraph (1) to apply for  
28 coverage from a health care service plan subject to this section.  
29 With respect to individual health benefit plans offered through the  
30 Exchange, an individual shall have 60 days from the date of a  
31 triggering event identified in paragraph (1) to select a plan offered  
32 through the Exchange, unless a longer period is provided in Part  
33 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
34 A of Title 45 of the Code of Federal Regulations.

35 (e) With respect to individual health benefit plans offered  
36 through the Exchange, the effective date of coverage required  
37 pursuant to this section shall be consistent with the dates specified  
38 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
39 Regulations, as applicable. A dependent who is a registered

1 domestic partner pursuant to Section 297 of the Family Code shall  
2 have the same effective date of coverage as a spouse.

3 (f) With respect to an individual health benefit plan offered  
4 outside the Exchange, the following provisions shall apply:

5 (1) After an individual submits a completed application form  
6 for a plan, the insurer shall, within 30 days, notify the individual  
7 of the individual's actual premium charges for that plan established  
8 in accordance with Section 10965.9. The individual shall have 30  
9 days in which to exercise the right to buy coverage at the quoted  
10 premium charges.

11 (2) With respect to an individual health benefit plan for which  
12 an individual applies during the initial open enrollment period  
13 described in subdivision (c), when the policyholder submits a  
14 premium payment, based on the quoted premium charges, and that  
15 payment is delivered or postmarked, whichever occurs earlier, by  
16 December 15, 2013, coverage under the individual health benefit  
17 plan shall become effective no later than January 1, 2014. When  
18 that payment is delivered or postmarked within the first 15 days  
19 of any subsequent month, coverage shall become effective no later  
20 than the first day of the following month. When that payment is  
21 delivered or postmarked between December 16, 2013, and  
22 December 31, 2013, inclusive, or after the 15th day of any  
23 subsequent month, coverage shall become effective no later than  
24 the first day of the second month following delivery or postmark  
25 of the payment.

26 (3) With respect to an individual health benefit plan for which  
27 an individual applies during the annual open enrollment period  
28 described in subdivision (c), when the individual submits a  
29 premium payment, based on the quoted premium charges, and that  
30 payment is delivered or postmarked, whichever occurs later, by  
31 December 15, coverage shall become effective as of the following  
32 January 1. When that payment is delivered or postmarked within  
33 the first 15 days of any subsequent month, coverage shall become  
34 effective no later than the first day of the following month. When  
35 that payment is delivered or postmarked between December 16  
36 and December 31, inclusive, or after the 15th day of any subsequent  
37 month, coverage shall become effective no later than the first day  
38 of the second month following delivery or postmark of the  
39 payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding subdivision (c) of Section 10291.5, a health insurer shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health

insurer shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(h) (1) A health insurer shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that insurer in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds who enroll in individual coverage through the Exchange and insureds who enroll in individual coverage outside the Exchange. Student health insurance coverage, as such coverage is defined at Section 147.145(a) of Title 45 of the Code of Federal Regulations, shall not be included in a health insurer's single risk pool for individual coverage.

(2) Each calendar year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health insurer's health benefit plans in the individual market shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health insurer may vary premium rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27. These additional benefits shall be pooled with similar benefits within the single risk

1 pool required under paragraph (1) and the claims experience from  
2 those benefits shall be utilized to determine rate variations for  
3 plans that offer those benefits in addition to essential health  
4 benefits.

5 (D) With respect to catastrophic plans, as described in subsection  
6 (e) of Section 1302 of PPACA, the expected impact of the specific  
7 eligibility categories for those plans.

8 (E) Administrative costs, excluding any user fees required by  
9 the Exchange.

10 (i) This section shall only apply with respect to individual health  
11 benefit plans for policy years on or after January 1, 2014.

12 (j) This section shall not apply to an individual health benefit  
13 plan that is a grandfathered health plan.

14 (k) If Section 5000A of the Internal Revenue Code, as added  
15 by Section 1501 of PPACA, is repealed or amended to no longer  
16 apply to the individual market, as defined in Section 2791 of the  
17 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
18 subdivisions (a), (b), and (g) shall become inoperative 12 months  
19 after the date of that repeal or amendment and individual health  
20 care benefit plans shall thereafter be subject to Sections 10901.2,  
21 10951, and 10953.

22 SEC. 3. No reimbursement is required by this act pursuant to  
23 Section 6 of Article XIII B of the California Constitution because  
24 the only costs that may be incurred by a local agency or school  
25 district will be incurred because this act creates a new crime or  
26 infraction, eliminates a crime or infraction, or changes the penalty  
27 for a crime or infraction, within the meaning of Section 17556 of  
28 the Government Code, or changes the definition of a crime within  
29 the meaning of Section 6 of Article XIII B of the California  
30 Constitution.

31 *SEC. 4. This act is an urgency statute necessary for the*  
32 *immediate preservation of the public peace, health, or safety within*  
33 *the meaning of Article IV of the Constitution and shall go into*  
34 *immediate effect. The facts constituting the necessity are:*

35 *In order to adjust the next open enrollment period for the*  
36 *individual health care coverage market as needed to comply with*  
37 *federal law, it is necessary that this act take effect immediately.*